ALBERTA BLUE CROSS®

LEVODOPA/CARBIDOPA INTESTINAL GEL SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				**COVERAGE TYPE**
LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			☐ Alberta Human Services ☐ Other _____
ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION

PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION	
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other	REGISTRATION NUMBER
ADDRESS				
CITY, PROVINCE			PHONE	FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED	

Please provide the following information for NEW requests

Note: For coverage of levodopa/carbidopa intestinal gel, the drug must be initiated by a movement disorder specialist who has appropriate training in its use and is practising in a movement disorder clinic that provides ongoing management and support.

Diagnosis ☐ Parkinson's Disease → advanced? ☐ Yes ☐ No

☐ Other (specify) _____

Previous therapy

1) The patient received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response?

☐ Yes ☐ No (explain) _____

2) The patient trialed frequent dosing of levodopa (at least five doses per day)?

☐ Yes → response ☐ severe disability associated with at least 25 percent of the waking day in the off state

☐ ongoing, bothersome levodopa-induced dyskinesias

☐ other (specify) _____

☐ No (explain) _____

3) The patient had an adequate trial of the following adjunctive medications? (Please check all that apply and indicate the name of the drugs utilized, where applicable and the patient's response to each. If there is a contraindication to a particular therapy, elaborate as to its nature.)

☐ Catechol-O-methyl transferase (COMT) inhibitor _____

☐ Dopamine agonist _____

☐ Monoamine oxidase (MAO-B) inhibitor _____

☐ Amantadine _____

Does the patient have severe psychosis or dementia? ☐ Yes ☐ No

Please provide the following information for RENEWAL requests

The patient has demonstrated a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability?

☐ Yes ☐ No (explain) _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE (YYYY-MM-DD)	Please forward this request to **Alberta Blue Cross, Clinical Drug Services** **10009 108 Street NW, Edmonton, Alberta T5J 3C5** FAX **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

LEVODOPA/CARBIDOPA INTESTINAL GEL SPECIAL AUTHORIZATION CRITERIA

Patients may or may not meet eligibility requirements as established by Alberta government-sponsored drug programs.

Criteria for coverage

LEVODOPA/CARBIDOPA INTESTINAL GEL (e.g. Duodopa) special authorization criteria

Special authorization coverage may be provided for the treatment of patients with advanced levodopa-responsive Parkinson's disease, who meet the following criteria:

1) The patient experiences severe disability associated with at least 25 percent of the waking day in the off state and/or ongoing, bothersome levodopa-induced dyskinesias, despite having tried frequent dosing of levodopa (at least five doses per day). Time in the off state, frequency of motor fluctuations and severity of associated disability should be assessed by a movement disorder subspecialist and be based on an adequate and reliable account from longitudinal specialist care, clinical interview of a patient and/or care partner, or motor symptom diary.

2) The patient has received an adequate trial of maximally tolerated doses of levodopa, with demonstrated clinical response.

3) The patient has failed or is intolerant to adequate trials of each of the following adjunctive medications, if not contraindicated: a catechol-O-methyl transferase (COMT) inhibitor, a dopamine agonist, a monoamine oxidase (MAO-B) inhibitor and amantadine.

4) The patient is able to administer the medication and care for the administration port and infusion pump. Alternatively, trained personnel or a care partner must be available to perform these tasks reliably.

5) The patient does not have a contraindication to the insertion of a percutaneous endoscopic gastrostomy-jejunostomy (PEG-J) tube.

6) The patient does not have severe psychosis or dementia.

7) Levodopa/carbidopa intestinal gel is initiated by a movement disorder subspecialist who has appropriate training in its use and is practising in a movement disorder clinic that provides ongoing management and support for patients receiving treatment.

Initial coverage may be approved for a period of 12 months.

Ongoing coverage may be considered only if the following criteria are met at the end of each 12-month period:

- The patient demonstrates a significant reduction in the time spent in the off state and/or in ongoing, bothersome levodopa-induced dyskinesias, along with an improvement in the related disability.

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